



OREGON MEDICAL BOARD REPORT

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www.oregon.gov/OMB

The mission of the Oregon Medical Board is to protect the health, safety and wellbeing of Oregon citizens by regulating the practice of medicine in a manner that promotes access to quality care.

OMB Endorses New Statewide Acute Opioid Prescribing Guidelines

In response to the dramatic increase in overdose deaths and hospitalizations for prescription opioid use, the Oregon Opioid Prescribing Guidelines Task Force reconvened to develop state-specific guidelines that would optimize care and improve patient safety in Oregon. The resulting *Oregon Acute Opioid Prescribing Guidelines: Recommendations for patients with acute pain not currently on opioids* was published in October 2018 and endorsed by the Oregon Medical Board at the beginning of January 2019.

The Board encourages all prescribing professionals to read and follow the Oregon Acute Opioid Prescribing Guidelines in their practices. The guidelines can be found, in their entirety, on pages three through six of this edition of the Oregon Medical Board Report and at <https://www.oregon.gov/oha/PH/PreventionWellness/SubstanceUse/Opioids/Documents/Acute-Prescribing-Guidelines.pdf>.

As communicated in the October 25, 2018, Oregon Health Authority press release, the guidelines were developed with the consensus of an external workgroup representing public health, health care, and coordinated care organization leaders. These guidelines build on Oregon prescribing guidelines for chronic pain, published in 2016. The acute prescribing guidelines focus on acute pain management for patients who are new to opioids. They are not intended for those who currently receive opioids nor for those with a history of substance use disorder.

Common examples of relevant clinical situations include wisdom teeth extractions, sports injuries, and post-surgical pain management. It is common practice for patients to be prescribed 30-day prescriptions in these settings. The new guidelines advise that the lowest effective dose of short-acting opioids be prescribed for no more than three days in most cases.

"While opioids are effective medications in acute pain management, many people do not use all of the pills that are prescribed by their doctors after an acute event," said Katrina Hedberg, MD, State Health Officer at OHA. "What this tells us is that patients may not need as many pills as we think, and other forms of pain management may be safer and just as effective. It also tells us that there are many excess pills sitting in medicine cabinets, which could be misused or stolen."

The guidelines could also help prevent patients with acute pain from becoming dependent on opioids long term. According to a 2017 analysis by the Centers for Disease Control and Prevention, 30 percent of those who received an initial 30-day prescription of opioid painkillers remained on opioids a year later.

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Statement of Purpose

The OMB Report is published to help promote medical excellence by providing current information about laws and issues affecting medical licensure and practice in Oregon.

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Supervising Physician Review

The Oregon Medical Board is committed to ensuring appropriate delegation and adequate supervision by all of its supervising physicians for the health, safety, and wellbeing of the public. A supervising physician is responsible for the actions of the physician assistant under his/her supervision at all times.

In March of 2019, the Board will conduct a review of randomly selected supervising physicians to ensure compliance with the laws and regulations governing supervision of physician assistants.

A supervising physician must maintain the most current practice agreement with the Board and notify the Board within 10 days of any changes to the agreement. A supervising physician is responsible for ensuring the physician assistant is competent to perform all duties delegated and is not practicing outside the scope of the practice agreement. A physician assistant may only dispense medication if the supervising physician is registered with the Board as a dispensing physician and approved by the Board.

Board staff will notify the randomly selected supervising physicians in March of 2019 by letter and e-mail. The supervising physicians must respond within 30 days. While the purpose of the survey is educational, failure to comply with this request may subject the supervising physician to a fine and further review by the Board.

For additional information regarding the requirements and responsibilities of supervising physicians, please visit: <https://oregon.gov/omb/licensing/Documents/supervising-physicians/supervising-physician-course.pdf>. +



The Foundation For Medical Excellence presents

32nd ANNUAL CHRONIC PAIN MANAGEMENT CONFERENCE

In cooperation with:

The College of Physicians and Surgeons of British Columbia

March 1-2, 2019

Hyatt Regency Hotel
Vancouver, British Columbia

Registration is available online at www.tfme.org

Pain Management Conference– March 1-2, 2019

\$450 US Funds for US residents

Advanced Skill Building Workshops – March 2, 2019 (1:30-5:00 pm)

\$225 US Funds for US residents

Acute Opioid Guidelines

In general, the guidelines advise against using opioids as the first-line therapy for mild to moderate pain. If opioids are deemed appropriate and likely effective for the patient, the guidelines emphasize the following principles:

- Evaluate the patient.
- Assess history of long-term opioid use or substance use disorder.
- Check the Prescription Drug Monitoring Program, which tracks prescribed controlled substances such as opioids and benzodiazepines.
- Provide patient education.
- Prescribe the lowest effective dose of short-acting opioids for no more than three days in most cases and no more than seven days in cases of more severe acute pain.
- Provide follow-up and reassess pain, healing, and function.
- Implement, monitor, and document pain management practices to ensure care safety and quality.

The Board thanks Joe Thaler, MD, OMB Medical Director, for his contribution to the Task Force along with many other health care professionals and experts. Please see <http://omb.oregon.gov/pain-management> for more information.

ACUTE OPIOID GUIDELINES

These Oregon opioid prescribing guidelines for acute pain provide general recommendations for assessment, documentation, cautions, and prescribing limits for patients not currently or recently treated with opioids (i.e., opioid-naïve) across several practice settings. More detailed guidelines for specific conditions and procedures by practice setting (e.g., dental, emergency department, post-operative) are being developed as companion recommendations to these guidelines. These companion guidelines will include recommendations for maximum opioid prescription amounts by severity and anticipated duration of acute pain.

Children, the elderly, and those with existing medical conditions require additional considerations (e.g., weight, metabolism, organ dysfunction) when prescribing opioids. While these acute pain guidelines cannot address every age group and medical condition, most of the principles are relevant for all patients. For example, these guidelines should be used when prescribing opioids to adolescents after dental procedures (e.g., after third molar [wisdom tooth] extractions) or sports-related injuries in adolescents.

APPROACH TO ACUTE PAIN

While pain is primarily a sensory response to physical tissue damage, there is a strong subjective component associated with the patient's experience of pain. When determining the most appropriate treatment for acute pain, consider the type of pain (e.g., musculoskeletal, neuropathic), the severity, and the expected duration. Depending on the acute condition, evidence-based non-opioid therapies may be the most effective. Always choose specific medications after reviewing precautions and contraindications and make schedule and dose adjustment as needed for each patient.

In general, opioids should not be considered first line therapy for mild to moderate pain in patients with limited past exposure to opioids (i.e., opioid naïve).

If other options are not appropriate or effective for acute pain, and the clinician deems that opioids will be effective, follow these recommendations before any new opioid prescription. Avoid prescribing opioids without a direct patient to prescribing clinician assessment (e.g., face-to-face or telemedicine).

EVALUATE THE PATIENT

- Identify cause and type of the acute pain (e.g., medical condition, post-op, injury). Determine whether the pain is likely to be responsive to opioid or non-opioid therapies.
- Assess severity of pain.
- Determine likely period for recovery/duration of acute pain.
- Assess age and other medical considerations that might affect opioid dose.
- Review other medications patient may be taking for pain, such as acetaminophen and non-steroidal anti-inflammatory drugs (NSAIDs). Note that these may cause drug interactions or produce toxic effects if taken with combination drugs, such as Tylenol #3.
- Document the results of this patient evaluation and the justification for prescribing an opioid.

ASSESS HISTORY OF LONG-TERM OPIOID USE AND/OR SUBSTANCE USE DISORDER

- Assess patient for history of substance use disorder (SUD). Opioids should be prescribed with great caution in patients with SUD. Include specific documentation of the indication for prescribing opioids in these patients.
- Assess patient for a history of long-term opioid treatment. Review records from other providers and be aware that, for a patient who could be tapering off opioids, a new opioid prescription could jeopardize this progress.
- Coordinate with other providers who have prescribed a controlled substance (e.g., opioids, benzodiazepines) to the patient. If a patient on long-term opioids or benzodiazepines presents for an acute condition causing pain, communicate with the primary clinician overseeing the long-term opioid/benzodiazepines use.
- Assess patient's use of alcohol or sedative medications. Be aware that these may exacerbate the sedative effects of opioids, and prescribe opioids with caution in these patients.

CHECK THE PRESCRIPTION DRUG MONITORING PROGRAM

- Check the Prescription Drug Monitoring Program (PDMP) to understand the patient's prescription history before prescribing opioids.
- Take note of chronic opioid use and any concurrent prescription for a benzodiazepine or other sedative hypnotics.

PROVIDE PATIENT EDUCATION

- Counsel patient about pain and expected duration before procedures or after injuries.
- Review with patient the risks and side effects of opioids.
- Provide an opioid safety handout and review with patient before prescribing.
- Counsel patient to avoid alcohol and other sedative medications when taking opioids.
- Counsel patient that using opioid combination medications (e.g., Tylenol #2-4, Vicodin, Percocet) with over-the-counter medications (e.g., Tylenol) may lead to toxicity.
- Provide information on safe storage and disposal of unused opioid medications.

AMOUNT AND TYPE*

- Use opioids with caution and only if necessary.
- Do not prescribe opioids without a direct patient to prescribing clinician assessment or document reason for the exception.
- Prescribe the lowest effective dose of short-acting opioids usually for a duration of less than 3 days; in cases of more severe acute pain, limit initial prescription to less than 7 days.
- Do not recommend a more than two-fold range of amount or timing of opioids. Never recommend dual ranges (e.g., 1-2 pills every 6 hours as needed for pain is appropriate, but 1-4 pills every 4-6 hours is not).

- If prescribing an opioid combination medication (e.g., Tylenol #3), assess patient's use of over-the-counter medications (e.g., Tylenol) to identify and explain potential acetaminophen or NSAID toxicity.
- Do not prescribe opioids and benzodiazepines simultaneously, unless there is a compelling justification.
- When pre-packaged opioids are dispensed in emergency departments, ensure that a system is in place to share information via the Prescription Drug Monitoring Program (PDMP).

* *Note: These guidelines use # days' supply as a simple method to indicate amount; however, it is a given that different medications have differing strengths. A table with recommended strengths of various medications is pictured below.*

WARNING:

USE OPIOIDS WITH CAUTION AND ONLY IF NECESSARY.

IF APPROPRIATE: OPIOID MEDICATION STRENGTH FOR ACUTE PAIN IN ADOLESCENTS AND ADULTS. IN MOST CASES, <3 DAYS' SUPPLY (<8 PILLS) WILL BE SUFFICIENT; FOR MORE SEVERE PAIN, <7 DAYS MAY BE NEEDED.

Codeine (e.g., Tylenol 3)	Oxycodone (e.g., Percocet)	Hydrocodone (e.g., Vicodin)	Hydromorphone (e.g., Dilaudid)	Morphine sulfate	Tramadol (e.g., Ultram)
30 mg	5 mg	5 mg	2 mg	15 mg	50 mg

PATIENT FOLLOW-UP

- Recommend appropriate follow-up for all patients, depending on condition for which patient has been seen (e.g., dental, post-op).
- Before providing a refill, re-assess the patient's pain, level of function, healing process, and response to treatment. Explore other non-opioid treatment options. Do not prescribe a refill of opioids without a direct patient to prescribing clinician assessment (e.g., face-to-face, telemedicine).
- After visits to urgent care and/or the emergency department (ED), ensure follow-up with an appropriate primary care medical or dental provider rather than providing additional opioid refills from the ED. Prescription opioids from the ED for severe acute injuries (e.g., fractured bones) should be in an amount that will last until the patient is reasonably able to receive follow-up care for the injury.

HEALTH CARE SYSTEMS/CLINIC RESPONSIBILITIES

- Endorse the Oregon guidelines for opioid prescribing, including the guidelines for chronic and acute pain.
- Adopt these guidelines as the standard of care for various practice settings.
- Implement the guidelines in the health care systems/clinic settings by ensuring they are included in work flow processes.
- For computerized provider order entry in an electronic health record (EHR), consider eliminating default amounts of opioids and make each opioid prescription an individualized, patient-centered decision. As an option, have clinic, hospital, or health system pharmacy order systems update the default to reflect recommended minimum dose outlined in this document (e.g., <8 pills).
- Monitor the results of guidelines implementation, reviewing overall opioid prescribing by health system and practice setting and for individual clinicians.
- Perform quality review of guideline implementation; identify best-practices for clinical settings and implement across the health system.
- Consider providing individual clinicians with a report card on their opioid prescribing practices, comparison with other clinicians in similar practice settings, and trends in prescribing over time.

Continued on page 6

ENDNOTES

1. Shah A, Hayes CJ, Martin BC. Characteristics of initial prescription episodes and likelihood of long-term opioid use – United States, 2006–2015. MMWR 2017; 66: 265–9 [cited 2018 Oct 8]. Available from: <https://www.cdc.gov/mmwr/volumes/66/wr/mm6610a1.htm>.
2. Hill MV, McMahon ML, Stucke RS, Barth RJ Jr. Wide variation and excessive dosage of opioid prescriptions for common general surgical procedures. Ann Surg. 2017;265(4):709–714.
3. Oregon Health Authority. Oregon opioid prescribing guidelines: Recommendations for the safe use of opioid medications [cited 2018 Oct 8]. Available from: <https://www.oregon.gov/oha/PH/PreventionWellness/SubstanceUse/Opioids/Documents/taskforce/oregon-opioid-prescribing-guidelines.pdf>.
4. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain – United States, 2016. MMWR Recomm Rep 2016; 65 (No. RR-1): 1–49 [cited 2018 Oct 8]. Available from: <https://www.cdc.gov/mmwr/volumes/65/rr/pdfs/rr6501e1.pdf>.

Please visit <http://omb.oregon.gov/pain-management> for more information on pain management. +

Oregon Pregnancy and Opioids Workgroup Recommendations

Opioid use among pregnant and parenting women and neonatal abstinence syndrome (NAS) are complex public health issues. They cut across health and behavioral health providers, families, child welfare, the criminal justice system, and other community organizations. In response to these issues, the Oregon Health Authority convened the Oregon Pregnancy and Opioids Workgroup to develop recommendations that can optimize the outcome for both mother and infant. The resulting *Oregon Pregnancy and Opioids Workgroup Recommendations* was published in March 2018 and endorsed by the Oregon Medical Board at the beginning of January 2019.

The Board encourages all prescribing professionals to read and follow the Oregon Pregnancy and Opioids Workgroup Recommendations in their practice. A list of brief recommendations can be found on page seven of this edition of the Oregon Medical Board Report. The full document can be reviewed at <https://oregon.gov/oha/PH/PreventionWellness/SubstanceUse/Opioids/Documents/Oregon-Pregnancy-and-Opioids-Recommendations.pdf>.

The workgroup included experts from a variety of disciplines, including maternity and pediatric health care providers, public health, child welfare, and substance abuse treatment. The group met from December 2017 to March 2018. The workgroup's report includes clinical recommendations for all women of reproductive age, as well as those specific to women with an opioid use disorder and their infants. The recommendations focus on care from preconception through the postpartum period, including monitoring of the infant. For these recommendations to be effective, health care providers must recognize the role that trauma and adverse childhood experiences (ACEs) play in substance use disorders. It is also important to incorporate trauma informed prevention and treatment in a significant way.

A variety of life experiences can lead to opioid-exposed pregnancies. These experiences include chronic pain or other conditions managed by medication, misuse of prescribed medication, recovery from opioid addiction and receiving MAT, and active abuse of heroin. Each of these experiences calls for differing prevention and intervention opportunities.

This report recognizes the barriers to optimal care faced by women with an opioid use disorder and their infants. The system and policy recommendations encourage Oregon health care leaders and policy makers to better support families affected by opioid use disorder.

RECOMMENDATIONS IN BRIEF:

Clinical Recommendations

Primary prevention (for all women)

1. Ask all women of reproductive age about their pregnancy intentions prior to initiation and continuation of any opioid, including medication-assisted treatment (MAT) for an opioid use disorder (OUD).
2. Ask all pregnant women and women seeking pregnancy or preconception care about opioid use.
3. For all pregnant women without an OUD, avoid prescribing opioids when possible but, if necessary, do so with safeguards in place.
4. Prevent opioid overdose.
5. Upon discharge after a delivery, encourage all women without an OUD who need ongoing pain treatment to use non-opioid therapies (i.e., NSAIDs). If opioids are indicated, they should receive a limited number of opioid pills to last until a scheduled follow-up visit and no more than seven days of treatment.

Secondary Prevention (for women with an opioid use disorder and their infants)

1. Coordinate care for pregnant and parenting women with an OUD.
2. Manage OUDs during pregnancy by following evidence-based approaches.
3. Include additional screenings and services when caring for pregnant women with an OUD.
4. Provide appropriate pain control for women with an OUD during labor.
5. Provide necessary postpartum services and support for women with an OUD.
6. Encourage breastfeeding for women with an OUD on MAT.
7. Closely monitor an infant born to a mother who used opioids during pregnancy. Manage care with a standardized protocol for the assessment and treatment of infants at risk for neonatal abstinence syndrome (NAS).

System and Policy Recommendations

1. The Oregon Health Authority, in partnership with the Oregon Maternal Data Center, should implement a surveillance strategy for in utero opioid exposure and NAS. The strategy should be mindful of any unintended negative consequences and seek a balance between patient confidentiality and the state's ability to truly understand the scope of the problem.
2. Oregon health care leaders and policy makers should work to advance systems change that supports families affected by OUD. +

Data Security

The Oregon Medical Board works diligently to protect licensee and applicant data. We keep our information systems up to date and comply with State of Oregon standards for information security. Data breaches have occurred at other health-related organizations and beyond. We encourage our licensees and applicants to protect themselves by checking their free credit report annually at www.annualcreditreport.com and practicing information security best practices:

- Use passwords longer than the minimum required, with upper, lower, numeric, and special characters
- Do not use the same username and password across services
- Connect only to trusted Wi-Fi networks
- Only submit information to websites when the web address in the address bar starts with "https"
- Avoid entering private information on shared computers
- Do not respond to unsolicited requests for private information



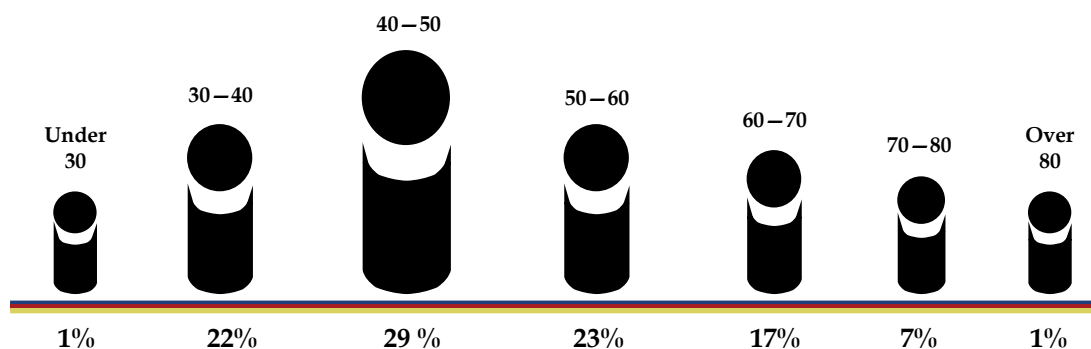
Annual Licensing Statistics

The OMB had 22,739 licensees as of December 31, 2018. Of that number, 20,230 held active* licenses to practice in Oregon. Another 858 individuals held limited licenses of various kinds.

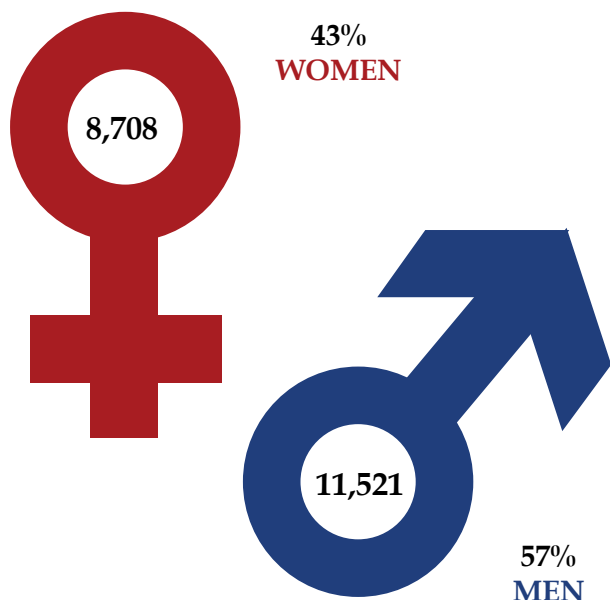
Status	Doctors of Medicine (MD)	Doctors of Osteopathic Medicine (DO)	Podiatric Physicians (DPM)	Physician Assistants (PA)	Acupuncturists (LAc)
Active	14,925	1,480	205	2,134	1,486
Inactive	1,335	132	9	119	56
Limited (<i>all types</i>)	693	154	11	0	0
Total	16,953	1,766	225	2,253	1,542

*Active licenses include: Active, Emeritus, Locum Tenens, Military/Public Health, Telemedicine, Telemonitoring, Teleradiology, Administrative Medicine, and Volunteer Emeritus

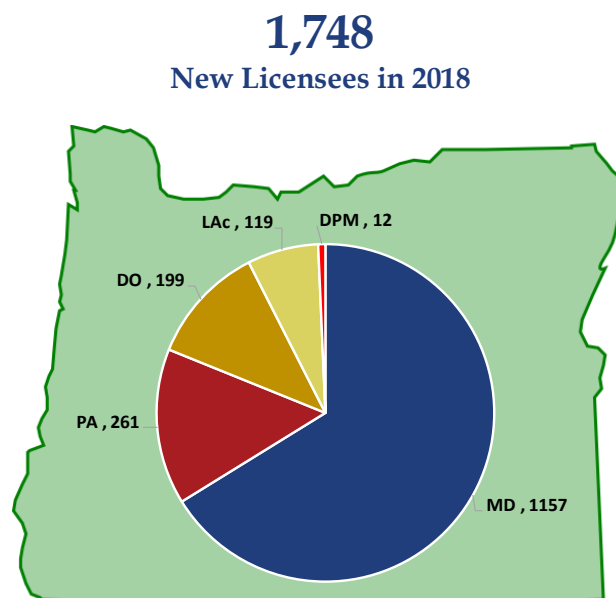
Active Licensees by Age



Active Licensees by Gender



New Licensees



Licensees by County

The data below reflects current practice addresses reported by licensees who have full licenses at practicing status. If a licensee provides practice addresses in more than one county, the licensee will be counted in each county. Therefore, the data does not represent full-time clinical practitioners in each county. *Data as of December 31, 2018.*

County (Seat)	MDs	DOs	DPMs	PAs	LAcS	Total	Population
Baker (Baker City)	71	8	2	14	2	97	16,750
Benton (Corvallis)	322	99	5	74	23	523	92,575
Clackamas (Oregon City)	1,160	145	22	168	106	1601	413,000
Clatsop (Astoria)	125	8	4	16	12	165	38,820
Columbia (St. Helens)	24	4	0	15	7	50	51,345
Coos (Coquille)	157	18	4	29	6	214	63,310
Crook (Prineville)	24	4	0	9	1	38	22,105
Curry (Gold Beach)	53	8	1	7	4	73	22,805
Deschutes (Bend)	645	79	9	174	76	983	182,930
Douglas (Roseburg)	222	44	8	54	7	335	111,180
Gilliam (Condon)	1	0	0	2	0	3	1,995
Grant (Canyon City)	15	2	0	1	2	20	7,415
Harney (Burns)	21	3	0	3	0	27	7,360
Hood River (Hood River)	113	8	1	20	18	160	25,145
Jackson (Medford)	694	82	12	134	62	984	216,900
Jefferson (Madras)	30	1	0	13	2	46	23,190
Josephine (Grants Pass)	161	32	6	46	18	263	85,650
Klamath (Klamath Falls)	157	12	2	25	4	200	67,690
Lake (Lakeview)	12	2	0	5	0	19	8,120
Lane (Eugene)	1,020	86	15	207	78	1406	370,600
Lincoln (Newport)	82	19	2	34	9	146	47,960
Linn (Albany)	175	46	4	48	7	280	124,010
Malheur (Vale)	137	20	1	34	0	192	31,845
Marion (Salem)	883	93	15	154	47	1192	339,200
Morrow (Heppner)	7	2	0	8	0	17	11,890
Multnomah (Portland)	4,909	351	51	650	789	6750	803,000
Polk (Dallas)	69	21	2	25	3	120	81,000
Sherman (Moro)	1	0	0	3	0	4	1,800
Tillamook (Tillamook)	58	3	2	10	7	80	26,175
Umatilla (Pendleton)	204	31	4	32	1	272	80,500
Union (La Grande)	68	13	2	4	5	92	26,900
Wallowa (Enterprise)	19	2	1	2	6	30	7,195
Wasco (The Dalles)	106	8	2	13	8	137	27,100
Washington (Hillsboro)	1,853	123	28	344	163	2511	595,860
Wheeler (Fossil)	3	0	0	3	0	6	1,480
Yamhill (McMinnville)	213	23	6	34	14	290	106,300

Annual Investigative Statistics

OMB Staff is continually preparing for and wrapping up Board and Committee meetings. For example, the Investigative Committee met eight times last year, each meeting spanning nine hours, and held two abbreviated meetings. Each quarterly Board meeting requires Board members to read, and staff to compile, over 10,000 pages of material. The following statistical reports are a snapshot of the resulting work.

Complaint Inquiries Received in 2018



1,537

Phone Calls



269

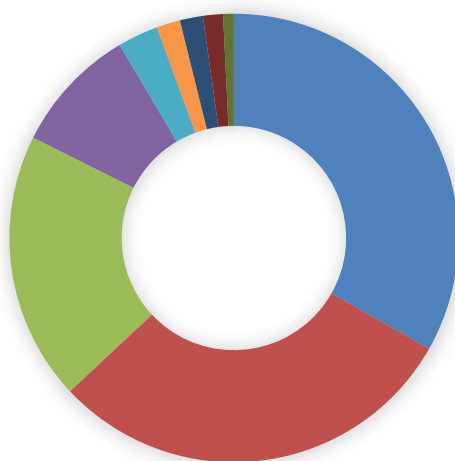
Emails



818

Complaints

Categories of Complaints



- Unprofessional Conduct - 33%
- Inappropriate Care - 30%
- Other or Misc - 19%
- Inappropriate Prescribing - 9%
- Malpractice Review - 3%
- Physical/Mental Illness or Impairment - 2%
- Sexual Misconduct - 2%
- Personal Substance Abuse - 1%
- Board Compliance - 1%

Source of Investigations	2016	2017	2018
Oregon Medical Board	56	76	93
Board or HPSP Non-Compliance	38	7	5
Hospital or Other Health Care Institution	26	31	33
Insurance Company	8	3	2
Malpractice Review	37	59	53
Other	72	56	83
Other Boards	7	9	11
Other Health Care Providers	53	69	65
Patient or Patient Associate	396	358	449
Pharmacy	6	4	3
Self-Reported	33	23	22

Final Dispositions of Investigations

Investigation Totals

	2016	2017	2018
Investigations Opened	721	708	819
Investigations Closed	684	682	732
Investigations Committee Interviews	65	55	47
Investigations Closed with Public Orders	77	74	65
Reportable Orders	63	65	51



Public Orders

	2016	2017	2018
Automatic Suspension	1	5	0
Corrective Action Order	19	8	9
Final Order	0	1	3
Stipulated Order	44	51	39
Voluntary Limitation	1	1	1

Final Dispositions of Investigations		2016	2017	2018
No Violations	No Apparent Violation	307	204	322
	Preliminary Investigation	96	120	116
	Prior to Committee Appearance	94	125	94
	Post Committee Appearance	4	4	0
	Letter of Concern/Prior to Committee Appearance	69	111	106
	Letter of Concern/Post Committee Appearance	14	14	12
	No Violation/App Withdrawal w/Report to Federation	5	15	5
	Temporarily Closed without Board Order	0	1	1
Public Orders	Corrective Action	19	8	9
	Stipulated Order	44	51	39
	Final Order (Includes Default Final Orders)	0	0	3
Total	Investigations Opened	721	708	819
	Investigations Closed	684	682	732
	Contested Case Hearings	1	1	0
	Investigative Committee Interviews	65	55	47
	Investigations Closed with Public Orders	77	74	65
	Reportable Orders (National Databanks)	63	65	51

Disciplinary sanctions imposed by the Board may include:

- Chaperone Requirement
- Educational Program or Coursework
- Fines
- Probation
- Requirement for a Practice Mentor
- Suspension of License
- Assessment of Hearing Costs
- Denial of License Application, Renewal, or Reactivation
- License Limitation(s) (Activities Restricted)
- Referral to the Health Professionals' Services Program
- Revocation of License

Duty to Report

Oregon Medical Board licensees are members of a professional community with an ethical obligation to regulate itself. Notifying the Board of concerns about other medical professionals upholds the profession's integrity and allows the Board to protect the public and offer remediation or resources to health care professionals whenever possible.

The following individuals, institutions and organizations are required by law to make reports to the Board:

- Board licensees and licensees of all health professional boards (including licensees with inactive status)
- Health care facilities (hospitals, clinics, nursing homes)
- The Oregon Medical Association
- The Osteopathic Physicians and Surgeons of Oregon
- The Oregon Podiatric Medical Association
- The Oregon Society of Physician Assistants
- The Oregon Association of Acupuncture and Oriental Medicine

In most cases, the law requires reports to be made **within 10 business days** of the event or learning about the conduct. Items that must be reported to the Board include:

- Criminal convictions or felony arrests;
- Adverse or official actions taken by other state licensing boards, health care institutions, or other agencies;
- Voluntary withdrawal, resignation, or limitation of practice; or
- Reasonable belief that another licensee has engaged in unprofessional or dishonorable conduct, is medically incompetent, or has a physical incapacity or impairment.

A report to the Board is not a finding of wrongdoing. Instead, the Board will look into the matter and decide whether a violation has occurred. Only the Board can determine if discipline is warranted.

Information provided to the Board, including the reporter's identity, is confidential. A person who reports in good faith is not subject to civil liability.

To make a report, contact the Board's Complaint Resource officer at 971-673-2702. For more information and links to the mandatory reporting laws, please visit <https://oregon.gov/omb/Investigations/Pages/Who-is-Required-to-Report.aspx>. +

What is an "Adverse" or "Official" Action?

Adverse or official actions include any formal action based on a finding of medical incompetence, unprofessional conduct, physical incapacity, or impairment. These formal actions may be taken by a health care facility, a health care system, or a government agency. Adverse or official actions include but are not limited to:

- Any restriction, limitation, loss or denial of privileges;
- Voluntary surrender or limitation of privileges while under, or to avoid, an investigation;
- Revocation of professional association membership;
- Revocation of specialty board certification;
- Disciplinary actions taken by another state licensing board;
- Denial, loss or restriction of DEA controlled substance registration; or
- Exclusion from participation in Medicare or Medicaid.

Oregon Administrative Rules

In 2018, the OMB had the following rulemaking activities:

Adopted 0 Rules • Amended 28 Rules • Repealed 0 Rules

Board Actions

October 16, 2018 – January 15, 2019

Many licensees have similar names. When reviewing Board Action details, please review the record carefully to ensure that it is the intended licensee.

INTERIM STIPULATED ORDERS

*These actions are not disciplinary because they are not final orders, but are reportable to the national data banks.**

DOUGLAS, Ben H., II, MD; MD19528
Tillamook, OR

On November 20, 2018, Licensee entered into an Interim Stipulated Order to voluntarily cease initiating chronic pain treatment except for patients enrolled in hospice or receiving end of life care; taper current patients to 90 MED or less or transfer care of the patient; limit prescribing for acute pain; taper concurrent benzodiazepines or transfer care of the patient; cease prescribing concurrent benzodiazepines or muscle relaxants with opioids; and obtain an EKG on all patients taking methadone at least once annually pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

HARRISON, Patrick T., DO; DO184926
Hermiston, OR

On January 2, 2019, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

SHILLAND, Eric W., DO; DO27920
Portland, OR

On November 26, 2018, Licensee entered into an Interim Stipulated Order to voluntarily cease initiating chronic pain treatment; cease initiating treatment for substance use disorder with any scheduled medications; cease writing new prescriptions for buprenorphine or buprenorphine/naloxone; taper current patients to 90 MED or less or transfer care of the patient except for patients currently taking buprenorphine or buprenorphine/naloxone; limit prescribing for acute pain; for patients taking buprenorphine or buprenorphine/naloxone, cease initiating treatment with benzodiazepines and wean current patients off benzodiazepines within 120 days or transfer care; taper concurrent benzodiazepines or

transfer care of the patient; cease prescribing concurrent benzodiazepines or muscle relaxants with opioids; and obtain an EKG on all patients taking methadone at least once annually pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

SILVERMAN, Burton L., MD; MD19465
Beaverton, OR

On November 30, 2018, Licensee entered into an Interim Stipulated Order to voluntarily cease initiating chronic pain treatment with opioids; taper current patients to 90 MED or less or transfer care of the patient; limit prescribing for acute pain; taper concurrent benzodiazepines or transfer care of the patient; cease prescribing concurrent benzodiazepines or muscle relaxants with opioids; and obtain an EKG on all patients taking methadone at least once annually pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

TROTTA, Adam L., MD; MD184793
Medford, OR

On December 28, 2018, Licensee entered into an Interim Stipulated Order to voluntarily withdraw from practice and place his license in Inactive status pending the completion of the Board's investigation into his ability to safely and competently practice medicine.

DISCIPLINARY ACTIONS

*These actions are reportable to the national data banks.**

CONRAD, Arthur K., Jr., MD; MD14553
Bend, OR

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order Licensee retires his medical license while under investigation.

CRAIGG, Gerald B.R., MD; MD22708
Walla Walla, WA

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; disciplinary action by another state of a license to practice; and willful violation any Board rule or order. This Order reprimands Licensee; assesses a \$5,000 civil penalty; prohibits Licensee from

(Continued on page 14)

treating Oregon chronic pain patients with DEA scheduled medications; prohibits Licensee from concomitantly prescribing benzodiazepines or muscle relaxants with Schedule II or III medications for acute pain; requires Licensee to comply with the Oregon Opioid Prescribing Guidelines; requires Licensee to register with and utilize the Oregon Prescription Drug Monitoring Program when initiating treatment with controlled substances; and requires Licensee to comply with his Washington Modified Stipulated Findings of Fact, Conclusions of Law and Agreed Order as well as report any modifications of this Agreed Order to the Oregon Medical Board.

DAVIS, William E., DO; DO07432

Klamath Falls, OR

On January 10, 2019, the Board issued a Default Order for unprofessional or dishonorable conduct; willful violation of any rule adopted by the board, or failing to comply with a board request; and prescribing a controlled substance without a legitimate medical purpose, or without following accepted procedures for examination of patients or without following accepted procedures for record keeping. This Order revokes Licensee's Oregon medical license.

FAIRCHILD, Suzanne C., LAc; AC150669

Eugene, OR

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct. With this Order, Licensee surrenders her acupuncture license while under investigation.

FARNEY, Thomas L., MD; MD15383

Hermiston, OR

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct and gross or repeated acts of negligence. With this Order, Licensee retires his medical license while under investigation.

HALL, Terrence J., MD; MD175340

Benton, IL

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct, and fraud or misrepresentation in applying for or procuring a license to practice in Oregon. With this Order, Licensee retires his medical license while under investigation.

YOON, Justin K., MD; MD162038

Pendleton, OR

On January 10, 2019, Licensee entered into a Stipulated Order with the Board for unprofessional or dishonorable conduct; conviction of any offense punishable by incarceration in a Department of Corrections institution or in a federal prison; and disciplinary action by another state of a license to practice. This Order reprimands Licensee; assesses a \$10,000 civil penalty, \$5,000 held in abeyance; requires Licensee to complete a pre-approved course on medical ethics; places Licensee on 5-year probation held in abeyance while Licensee's license is inactive; and requires Licensee to complete 192 hours of community service.

PRIOR ORDERS MODIFIED OR TERMINATED

CHEN, Poly, MD; MD29276

Corvallis, OR

On January 10, 2019, the Board issued an Order Terminating Stipulated Order. This Order terminates Licensee's 2016 Stipulated Order.

KAHN, Heather A., MD; MD22858

Grants Pass, OR

On January 10, 2019, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's January 29, 2016, Interim Stipulated Order.

SOLDEVILLA, Francisco X., MD; MD14348

Portland, OR

On January 10, 2019, the Board issued an Order Terminating Interim Stipulated Order. This Order terminates Licensee's 2018 Interim Stipulated Order.

NON-DISCIPLINARY BOARD ACTIONS

*These actions are not disciplinary and are not reportable to the national data banks.**

CORRECTIVE ACTION AGREEMENTS

These agreements are not disciplinary orders and are not reportable to the national data banks unless they relate to the delivery of health care services or contain a negative finding of fact or conclusion of law. They are public agreements with the goal of remediating problems in the Licensees' individual practices.*

DESAI, Rahul N., MD; MD28444

Beaverton, OR

On January 10, 2019, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved course on professional boundaries.

**KIMURA, Hidenao, MD; MD19944
Tualatin, OR**

On January 10, 2019, Licensee entered into a non-disciplinary Corrective Action Agreement with the Board. In this Agreement, Licensee agreed to complete a pre-approved CPEP education plan.

**CONSENT AGREEMENTS FOR RE-ENTRY TO
PRACTICE**

*These actions are not disciplinary and are not reportable to the national data banks.**

**BODENNER, Elizabeth K., LAc; AC185461
Portland, OR**

On October 22, 2018, Applicant entered into a Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Applicant agreed to complete a 320-hour mentorship with a Board-approved clinical supervisor; and complete 120 hours of continuing education units.

**HUBER, Nancy R., PA; PA179554
Portland, OR**

On November 9, 2018, Licensee entered into a Consent Agreement for Re-Entry to Practice with the Board. In this Agreement, Licensee agreed to specific requirements regarding supervision and chart review from her supervising physician, and that her supervising physician would submit reports to the Board regarding her progress in her return to the practice of medicine; to obtain Board approval of her supervising physician and practice setting; and to complete 19 hours of CME prior to December 31, 2018.

Current and past public Board Orders are available on the OMB website: <http://omb.oregon.gov/boardactions>.

**National Practitioner Data Bank (NPDB) and Federation of State Medical Boards (FSMB). +*



The Oregon Wellness Program promotes Oregon Healthcare Professionals' well-being through education, coordinated regional counseling services, telemedicine services, and research.

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ENROLLMENT REQUIRED FOR OREGON HEALTH PLAN (OHP) PRESCRIBERS

The Oregon Health Plan only covers prescriptions if they are written by enrolled providers and filled at enrolled pharmacies. The Oregon Health Authority (OHA) encourages all Oregon prescribing providers and pharmacies to enroll as Oregon Health Plan providers. Enrollment will ensure that prescriptions written for Oregon Health Plan members are appropriately filled.

The enrollment requirement has been postponed from November 13, 2018, to March 1, 2019, in order to avoid any interruptions to the prescription therapy for Oregon Health Plan members.

To see whether you are already enrolled with OHA, use OHA's verification tool at www.oregon.gov/ProdPortal/.

How to enroll with OHA

Prescribing providers can enroll using the [OHP 3113](#) form. Pharmacies and other providers seeking direct reimbursement from OHA will need to complete a packet of four enrollment forms.

To learn which forms to complete and submit, visit OHA's Provider Enrollment page at www.oregon.gov/oha/HSD/OHP/Pages/Provider-Enroll.aspx.

Questions?

About prescriber enrollment: Contact Provider Enrollment at 800-336-6016 (Option 6) or provider.enrollment@dhs.oha.state.or.us.

About fee-for-service prescription claims: Contact the Pharmacy Call Center at 888-202-2126.

About coordinated care organization (CCO) claims: Contact the CCO.

UPCOMING MEETINGS

February 7, 7:30 a.m.
Investigative Committee

March 7, 7:30 a.m.
Investigative Committee

March 13, 5:00 p.m.
**Administrative Affairs
Committee**

April 11-12, 8:00 a.m.
Board Meeting

May 2, 7:30 a.m.
Investigative Committee

May 17, 12:00 p.m.
EMS Advisory Committee

OFFICE CLOSURES

Monday, February 18
Presidents' Day

Monday, May 27
Memorial Day

OFFICE HOURS

8:00 a.m. - 5:00 p.m.
(closed noon to 1:00 p.m.)

CONTACT

E-mail: info@omb.oregon.gov
Phone: 971-673-2700

APPLICANT/LICENSEE SERVICES (*new applications, renewals, address updates, practice agreements, and supervising physician applications*):

<https://omb.oregon.gov/login>

LICENSING CALL CENTER:

9 am to 12 pm and 1 pm to 3 pm

Phone: 971-673-2700

E-mail: licensing@omb.oregon.gov

SIGN UP TO RECEIVE E-MAIL NOTICES:

Administrative Rules:

<https://omb.oregon.gov/subscribe-rules>

Board Action Reports:

<https://omb.oregon.gov/subscribe-actions>

EMS Interested Parties:

<https://omb.oregon.gov/subscribe-ems>

OMB Report (*quarterly newsletter*):

<https://omb.oregon.gov/subscribe-newsletter>

Public Meeting Notice:

<https://omb.oregon.gov/subscribe-meetings>

Quarterly Malpractice Report:

<https://omb.oregon.gov/subscribe-malpractice>